NC DMA Pharmacy Request for Prior Approval

Lyrica

Recipient Information **DMA-3105**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Lyrica** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

1. Does the patient have a diagnosis of seizure disorder? ☐ Yes ☐ No
2. Has patient received the requested anticonvulsant in the past 6 months? ☐ Yes ☐ No

Request for Lyrica for diagnosis OTHER THAN seizure disorder:

3. Does the patient have a diagnosis of Neuropathic pain AND have a documented failure with a 60 day trial of at least 1 of the following agents in the past 12 months (tricyclic antidepressant, gabapentin, carbamazepine, valproic acid)?
☐ Yes ☐ No List: _____

4. Does the patient have a documented adverse reaction or contraindication that precludes trial with tricyclic antidepressants, gabapentin, carbamazepine, valproic acid? ☐ Yes ☐ No
List: _____

5. Does the patient have a diagnosis of Fibromyalgia AND have a documented failure with a 60 day trial of at least 2 of the following agents in the past 12 months (antidepressant, cyclobenzaprine, gabapentin)? ☐ Yes ☐ No
List: _____

6. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 of the following agents (antidepressant, cyclobenzaprine, gabapentin)? ☐ Yes ☐ No
List: _____

7. Does the patient have a diagnosis of anxiety disorder AND a documented failure with a 60 day trail of a Selective Serotonin Reuptake Inhibitor (SSRI) in the past 12 months? ☐ Yes ☐ No
List: _____

8. Does the patient have a documented adverse reaction or contraindication that precludes trial of SSRI? ☐ Yes ☐ No
List: _____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp V.01